Electronically Delivered

February 19, 2025

Licensee
Marywood
915 Kenwood Avenue
Duluth, MN 55811

RE: Project Number(s) SL31068016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31068016-0 On January 6, 2025, through January 9, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 45 resident(s); 45 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 7, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of three employees (unlicensed personnel (ULP)-G).	0 650		

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0 650	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on January 6, 2025, at 10:07 a.m. to 11:17 a.m., licensed assisted living director (LALD)-A stated human resources was responsible for maintaining employee records. ULP-G had a hire date of September 6, 2022, to provide assisted living services to the licensee's residents. On January 7, 2025, at 7:25 a.m., the surveyor observed ULP-G administering R6's scheduled morning medications. ULP-G's employee record lacked evidence ULP-G had documentation of annual performance reviews that defined areas of improvement needed and training needs. On January 9, 2025, at 10:35 a.m., LALD-A stated they were unable to find an annual performance review in ULP-G's employee record. LALD-A stated they believe ULP-G's annual performance review had been completed; however, stated there seemed to be a "gap" getting the appropriate paperwork to human resources.	0 650		

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0 650	Continued From page 5 The licensee's Performance Review policy March 3, 2022, indicated the licensee would provide all associates the opportunity to have their performance evaluated annually based on the associate's current job responsibilities. The completed evaluations would be returned to human resources where they would be retained in the associate's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention	0 660		

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0 660	Continued From page 6 program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included ensuring the completion of a two-step TST's (tuberculin skin test) or other evidence of TB screenings such as a blood test was completed for one of three employees, (unlicensed personnel (ULP)-F). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on January 6, 2025, at 10:07 a.m. to 11:17 a.m., licensed assisted living director (LALD)-A stated human resources was responsible for managing employee TB testing and screenings. The licensee's Facility TB Risk Assessment dated October 10, 2024, indicated a low risk level for transmission of TB. ULP-F had a hire date of March 4, 2024, to provide assisted living services to the licensee's residents. On January 7, 2024, at 8:26 a.m., the surveyor observed ULP-F administering R4's scheduled morning medications.	0 660		

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0 660	Continued From page 7 ULP-F's employee record included a Baseline TB Screening Tool for Health Care Workers (HCWs) dated February 21, 2024, which indicated ULP-F completed the first step TST on February 21, 2024; however, ULP-F had not completed the TST second test or other evidence of TB screenings such as a blood test as required. On January 9, 2025, at 10:35 a.m., LALD-A stated ULP-F's employee record did not include any evidence ULP-F had a second TST completed or other evidence a blood test was completed. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs." The licensee's Tuberculosis Program for Associates policy dated October 1, 2024, indicated If TST is used as the baseline testing, 2-step testing is recommended for HCP and caregivers who have not had TST testing previously or have only had one negative TST test greater than 12 months ago. If 2 or more TST tests have been previously performed, all results are negative, and documentation of results is available, a one-step TST may be performed	0 660		

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0 660	Continued From page 8 before hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the	0 780		

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0 780	Continued From page 9 Minnesota Fire Code. The deficient conditions have the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with the resident services director (RSD)-Q and environmental services director (ESD)-R on January 8, 2025, between 11:00 a.m. and 3:00 p.m. the following deficient condition was observed: FIRE SPRINKLER HEAD: The surveyor observed that the storage closet in the kitchen of the Sunrise Pod did not have a fire sprinkler head in it. The surveyor explained to the RSD-Q and ESD-R that fire sprinkler heads were in the other three kitchen storage closets so one shall be installed in the Sunrise storage closet. The deficient condition was visually verified by the RSD-Q and ESD-R accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 810	Continued From page 10	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire	0 810		

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0 810	Continued From page 11 safety and evacuation plan with the required content and the licensee failed to document required fire safety evacuation training for employees and residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on January 8, 2025, at approximately 2:00 p.m. with the resident services director (RSD)-Q and environmental services director (ESD)-R on the fire safety and evacuation plan for the facility and training records for the employees and residents. FIRE/EVACUATION PLAN: While on tour of the facility the surveyor asked two employees what the emergency exit buttons near the kitchens on the first floor and neither of them knew what the buttons were for. The RSD-Q and ESD-R did provide documentation of training for employees for the system when it was installed. The emergency exit buttons and door release were not part of their fire safety and evacuation plan. The surveyor explained to the RSD-Q and ESD-R that the fire safety and evacuation plan shall be updated with the newly installed delayed egress locking system including how the emergency exit	0 810		

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0 810	Continued From page 12 buttons operate and that all employees shall be trained on this procedure and document the training. TRAINING: Record review indicated the licensee failed to document fire safety and evacuation training for the employees at new hire and at least twice a year thereafter and offer the residents the training at least once a year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 13 (BGS) were submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for four of eight on-call employees (registered nurse (RN)-J, RN-K, RN-L, RN-N). This had the potential to affect all 45 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During entrance conference on January 6, 2025, at 10:07 a.m., to 11:17 a.m., licensed assisted living director (LALD)-A stated the licensee utilized on-call RNs who were employed by the same management company [company name] to provide on-call RN services via telephone for the licensee's residents. LALD-A stated the on-call RNs took call for the licensee Monday through Friday 7:00 p.m. through 7:00 a.m., and weekends Friday 7:00 p.m. to Monday 7:00 a.m. LALD-A stated the RN on-call contact numbers and information was posted at the nurses station on each floor. The licensee's Nursing On Call Phone Numbers posted on the RN supervisors door on the 2nd floor indicated the on-call support nurse was to be contacted Monday through Friday 7:00 p.m. to 7:00 a.m., and weekends Friday 7:00 p.m. through Monday 7:00 a.m. When to call: resident needs such as prn (as needed)	01290		

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	31068	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 14 medications, events such as a fall, medication error, change in condition, urgent resident facing situations, elopement, vulnerable adult questions, clinical related or documentation, offline EMAR (electronic medical administration record). On January 7, 2025, at 11:31 a.m., regional director of housing services (RDOHS)-H stated the on-call RNs worked strictly remotely via telephone and would not come into the facilities. RDOHS-H stated they were aware of the requirements from previous surveys and the on-call RNs should have been affiliated with the licensee's HFID 31068. On January 7, 2025, at 11:43 a.m., RDOHS-H provided the surveyor with the on-call RNs background checks and stated they have been working on affiliating each on-call RN's BGS with the licensee's HFID 31068 which began after the surveyor requested the licensee's DHS (Department of Human Services) BGS employee roster. RDOHS-H stated the on-call RN's BGS were not previously affiliated with the licensee's HFID 31068 prior to the surveyors request. RN-J RN-J was licensed October 10, 2007, and was hired by the licensee's management company to provide RN on-call services for multiple sites. RN-J's background check was cleared May 17, 2024; however, was not affiliated with the licensee's HFID 31068. RN-K RN-K was licensed January 6, 2017, and was hired by the licensee's management company to provide RN on-call services for multiple sites. RN-K's background check was cleared October 2, 2024; however, was not affiliated with the	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

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01290	Continued From page 15 licensee's HFID 31068. RN-L RN-L was licensed July 2, 2017, and was hired by the licensee's management company to provide RN on-call services for multiple sites. RN-L's background check was cleared November 27, 2024; however, was not affiliated with the licensee's HFID 31068. RN-N RN-N was licensed August 7, 2002, and was hired by the licensee's management company to provide RN on-call services for multiple sites. RN-J's DHS BGS clearance letter was cleared January 6, 2023; however, was not affiliated with the licensee's HFID 31068 until after the surveyor requested the licensee DHS NetStudy employee roster. The licensee's Background Checks policy dated March 3, 2022, indicated employees, contractors, and regularly scheduled volunteer of the facility are subject dot the background study requirement by section 144.057 and may be disqualified under chapter 245C. All employees must pass a background study and all contractors or volunteers with direct resident contact are require to have a background study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

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01640	Continued From page 16 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and/or resident's representative to document agreement on the services to be provided for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: _____ B. WING _____	01/09/2025

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MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

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01640	Continued From page 17 The findings include: R3's Service Plan with an effective date December 31, 2024, did not include a signature or other authentication from R3 or R3's representative documenting agreement on services provided. In addition, R3's Service Plan lacked a signature or other authentication of the licensee's representative. R3's services received include assistance with dressing, grooming, toileting, transfers, ambulation, medication administration, housekeeping and laundry. On January 7, 2025, at 10:04 a.m., the surveyor observed unlicensed personnel (ULP)-F administering R3's Novolog (fast-acting) and Lantus (long-acting) insulins. On January 8, 2024, acting director of nursing (ADON)-E stated they were unable to find a signed service plan for R3. ADON-E stated there have been a few changes in leadership and does not know why R3's service plans were unauthenticated. The licensee's Monitoring of Residents and Their Service Plan policy dated August 1, 2021, indicated the service plan would be signed by the resident and/or resident's representative and the RN (registered nurse). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

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01890	Continued From page 18 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained to include the opened and/or expiration date for time sensitive medications administer by the licensee for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on January 6, 2025, at 10:07 a.m. to 11:17 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents of the facility. R3's diagnosis included diabetes and dementia. R3's Service Plan dated December 31, 2024, indicated R3 received medication administration services.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

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01890	Continued From page 19 R3's prescriber orders dated September 23, 2024, included the following -Novolog FlexPen (fast-acting insulin) 100 unit/milliliter (u/ml) 30 units and per sliding scale dose three times a day; and -Lantus Solostar (long-acting insulin) 100 u/ml inject 30 units every morning. R3's January 2025 Medication Administration Record (MAR) indicated R3 received Novolog FlexPen insulin 30 units daily and Lantus Solostar seven units three times a day along with sliding scale doses. On January 7, 2025, at 10:04 a.m., the surveyor observed R3's locked medication cabinet in R3's room with unlicensed personnel (ULP)-F. ULP-F primed R3's Lantus Solostar insulin pen of two units, dialed 30 units of insulin and administered into R3's left lower abdomen. At 10:09 a.m., ULP-F primed R3's Novolog insulin of two units, dialed of a total of 10 units of insulin and administered into lower abdomen. R3's Novolog and Lantus insulin pens lacked the date the insulin pens had been opened and when the insulin would expire. ULP-F stated the staff who opened R3's insulin pens should have written the date the insulins were opened. On January 8, 2025, at 9:22 a.m., acting director of nursing (ADON)-E stated staff were trained to write the date the insulins, eye drops and inhalers were opened. The manufacturer's instructions for Novolog insulin aspart injection FlexPen dated February 2023, directed to discard 28 days after opened. The manufacturer's instructions for Lantus	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31068	A. BUILDING: _____ B. WING _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARYWOOD	915 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 20 Solostar pre-filled injection pen dated December 1, 2021, directed to discard 28 days after opened. The licensee's Storage of Medications policy dated August 1, 2021, indicated the RN (registered nurse) would provide education on proper storage including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *01/07/25*
Time: 11:15:00
Report: 1016251002

Food and Beverage Establishment Inspection Report

Location:

Marywood - CLIFF ROCKS
915 Kenwood Avenue
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0039371
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2185228904
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
STAFF CFPM CERTIFICATE IS EXPIRED . RENEW AND POST.
Comply By: 01/31/25

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Sink/Surface Cleaner: = 700 PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 153 Degrees Fahrenheit - Location: CHICKEN
Violation Issued: No

Process/Item: Hot Holding
Temperature: 144 Degrees Fahrenheit - Location: CHICKEN
Violation Issued: No

Process/Item: Hot Holding
Temperature: 138 Degrees Fahrenheit - Location: TATER TOTS
Violation Issued: No

Type: Full
Date: *01/07/25*
Time: 11:15:00
Report: 1016251002
Marywood - CLIFF ROCKS

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: Degrees Fahrenheit - Location: WATERMELON
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: TOMATO
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

COMMENTS:

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016251002 of 01/07/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
MARK

Signed:_____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *01/07/25*
Time: 11:12:00
Report: 1016251003

Food and Beverage Establishment Inspection Report

Location:

Marywood - LIVING WATERS
915 Kenwood Avenue
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0039371
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2185228904
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
STAFF CFPM CERTIFICATE IS EXPIRED . RENEW AND POST.
Comply By: 01/31/25

Surface and Equipment Sanitizers

Sink/Surface Cleaner: = 700 PPM at Degrees Fahrenheit
Location:
Violation Issued: No

Hot Water: = at 169 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 173 Degrees Fahrenheit - Location: CHICKEN
Violation Issued: No

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: SOUP
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Type: Full
Date: *01/07/25*
Time: 11:12:00
Report: 1016251003
Marywood - LIVING WATERS

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: TOMATO
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: CREAM
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016251003 of 01/07/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
MARK

Signed:_____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us